.1. **Material Transmitted and Purpose** -- Transmitted with this Manual Letter are revisions to Service Chapter 535-05, Medicaid State Plan Personal Care Services Policies and Procedures.

Par. 2. **Effective Date** –April 22, 2013

Definitions 535-05-10

1. ”Activities of Daily Living (ADLs)” means physical activities routinely performed on a daily basis by an individual and generally includes bathing, dressing, eating, toileting, transferring, maintaining continence, and mobility.

2. “Authorizing agent” means a home and community based service case manager employed by a county social service board or a developmental disabilities employed by a regional human service center.

3. “Basic care assistance provider” means an entity that is licensed as a basic care facility; is not owned or administered by state government; does not specifically provide services for individuals with traumatic brain injury or Alzheimer’s disease or related dementia; and is enrolled with the Department as such.

4. “Family Home Care” The provision of room, board, supervisory care, and personal services daily, to an eligible elderly or disabled person by a qualified service provider, in the home of the client or the home of the qualified service provider who meets the definition of a family member as defined in N.D.C.C 50-06.2-02(4).

~~4.~~ 5. “Instrumental Activities of Daily Living (IADLs)” means complex life activities routinely performed by an individual such as housework, laundry, meal preparation, taking medications, shopping, outside mobility, management of money, personal hygiene, and use of telephone.

~~5.~~ 6. "Level A personal care services" means the level of care for an individual meeting the minimum eligibility criteria for personal care services.

~~6.~~ 7. "Level B personal care services" means the level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to the minimum eligibility criteria for personal care services.

~~7.~~ 8. "Level C personal care services" means the level of care for an individual meeting the nursing facility or ICF/MR level of care criteria in addition to having an impairment in 5 ADLS.

~~8.~~ 9. "Long term care need" means the need for the services available under the SPED Program, ExSPED Program, Medicaid Waiver Program, or the Medicaid State Plan Personal Care Option that is anticipated to exceed 30 days.

~~9.~~ 10. "Personal care service provider" means a qualified service provider or a basic care assistance provider.

~~10.~~11. "Personal care services" means services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands on assistance or cuing so that the individual can perform a task without direct assistance.

12. "Qualified Family Member" the spouse or one of the following relatives, or the current or former spouse of one of the following relatives, of the elderly or disabled person: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew. (Current or former spouse refers to in-law relationships.)

~~11.~~ 13. "Qualified service provider" means a county social service board, agency, or independent contractor that agrees to meet standards for service and operations established by the North Dakota Department of Human Services pursuant to NDCC 50-06.2-02(6) and NDAC 75-03-23.

~~12.~~ 14. "Unit" means either a 15-minute increment or a day.

Personal Care Eligibility Requirements 535-05-15

To qualify for coverage of personal care services, an individual must have applied for and been found eligible for Medicaid benefits

And

1. Eligibility criteria for **Level A (up to 480 units per month), Daily Rate care, or Basic Care** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing

        ii. Dressing

        iii. Eating

        iv. Toileting

        v. Continence

        vi. Transferring

        vii. Inside Mobility

    Or

    b. Be impaired in at least THREE of the following IADLs:

        i. Meal Preparation

        ii. Housework

        iii. Laundry

        iv. Taking medications

2. Eligibility for **Level B (up to 960 units per month)** includes:

    a. Be impaired in at least one of the following ADLS of:

        i. Bathing

        ii. Dressing

        iii. Eating

        iv. Toileting

        v. Continence

        vi. Transferring

        vii. Inside Mobility

    Or

    b. Be impaired in at least THREE of the following IADLs:

        i. Meal Preparation

        ii. Housework

        iii. Laundry

        iv. Taking medications

    AND

    c. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

3. Eligibility for **Level C (up to 1200 units per month)** includes:

    a. Be impaired in at least five of the following ADLS of:

        i. Bathing

        ii. Dressing

iii. Eating

iv. Toileting

v. Continence

vi. Transferring

vii. Inside Mobility

AND

b. Meet the nursing facility level of care criteria set forth at NDAC 75-02-02-09 or meets ICF/MR level of care criteria.

AND

c. None of the 300 hours (1200 units) approved for personal care services can be allocated to the tasks of laundry, shopping, or housekeeping.

AND

d. Have written prior approval for this service from a HCBS Program Administrator, Medical Services Division, Department of Human Services. The approval must be updated every three months.

After completing a comprehensive needs assessment the individual's case manager shall complete Section II of Personal Care Services Plan, SFN 662, to determine if the individual qualifies for personal care services. Section II allows the case manager to determine the level of impairment an individual is experiencing, based on specific medical, emotional and cognitive status. An individual must be impaired (have a score of at least 2) for any 1 ADL, or impaired (a score of at least 1) in 3 of the 4 IADLs. See the Instructions for Completing the Functional Assessment on scoring ADLs and IADLs.

The assessment measures the degree to which an individual can perform various tasks that are essential to independent living. Information on each of the ADLs or IADLs can be collected by observation, by direct questioning

of the individual, or by interview with a significant other. The case manager shall maintain documentation supporting the level of impairment and shall include the following information if applicable:

1. Reason for inability to complete the activity or task
2. Kind of aid the individual uses (e.g., a grab bar or stool for bathing)
3. Kind of help the individual requires (e.g., preparing the bath, washing back and feet, complete bed bath) and the frequency of the need to have the help (e.g. units of services needed)
4. Who provides the help
5. Reasons for inability of a spouse or parent of a minor child to perform the activity or task for the individual
6. The individual's health, safety and welfare needs that need to be addressed
7. Document the anticipated outcome as a result of service provision
8. Other pertinent information

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

A comprehensive assessment must be completed initially before any personal care services can be authorized and annually thereafter. A review of the individual's needs must be completed every six months or when there is a significant change in the individual's needs.

Limitations and Non-covered Services 535-05-25

1. Personal care services may not include skilled services performed by persons with professional training.

2. An individual receiving personal care services may not be an inpatient or resident of a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental disease.

3. Personal care services may not include home delivered meals; services performed primarily as housekeeping tasks; transportation; social activities; or services or tasks not directly related to the needs of the individual such as doing laundry for family members, cleaning of areas not occupied by the ~~individual~~ recipient, or shopping for items not used by the ~~individual~~ recipient or for tasks when they are completed for the benefit of the client and the provider.

4. Meal preparation is limited to the maximum units set by the department. Laundry, shopping, and housework tasks when provided as personal care services must be incidental to the provision of other personal care tasks and cannot exceed 30% of the total time authorized for the provision of all personal care tasks. Personal care services tasks of laundry, shopping, and housekeeping are limited to the maximum units set by the department, and the cap cannot be exceeded under other home and community-based services funding sources.

5. Services provided by a spouse, parent of a minor child, or legal guardian are not covered.

6. Care needs of the individual that are outside the scope of personal care services are not covered.

7. Services provided in excess of the services or hours authorized by the case manager in the individual's approved service plan are not covered.

8. Authorized personal care services may not exceed 120 hours (480 units) per month for Level A Personal Care Services or 240 hours (960 units) per month for Level B Personal Care Services, and 300 hours (1200 units) per month for Level C Personal Care Services.

9. Personal care services may only be provided when the needs of the eligible individual exceed the abilities of a spouse or parent(s) of a minor child to provide such services. Personal care services may not be substituted when a spouse or parent(s) of a minor

child refuses or chooses not to perform the service. Personal care services may be provided during periods when a spouse or parent(s) of a minor child is gainfully employed if such services cannot be delayed until the spouse or parent(s) is able to perform them.

10. Personal care services may not be provided for tasks that are otherwise age appropriate or generally needed by an individual within the normal stages of development.
11. The combination of personal care services and hospice service requires prior approval from the Department.
12. Payment for the tasks of laundry, shopping, housekeeping, meal preparation, money management, and communication cannot be made to a provider who lives with the client and is a relative listed under the definition of family home care under subsection 4 of North Dakota Century Code section 50-06.2-02 or is a former spouse.

Case Management 535-05-35

Case management for an individual applying for or receiving personal care services shall be the responsibility of a county social service board HCBS case manager except when the individual is also receiving a service(s) through the developmental disabilities division. Case management for personal care services for an individual receiving a service(s) through the DD division shall be the responsibility of a DD case manager. If the individual is not receiving service(s) through the DD Waiver, they have the right to choose the provider of case management services.

The case manager is responsible for assessing an individual's needs for personal care services, developing a comprehensive care plan that includes identification of tasks and times required to perform tasks, assisting the individual with obtaining a personal care service provider, monitoring and reassessing needs on a periodic basis, and terminating services when appropriate.

Decisions regarding personal care services for an incapacitated client are health care decisions that may be made pursuant to North Dakota Century Code section 23-12-13.

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required by this chapter for each month for which benefits are sought.

The case manager must schedule an appointment for an initial assessment no later than 5 working days after receiving a request for personal care services and must complete an initial comprehensive assessment no later than 10 working days after receiving a request for personal care services. All contacts with an individual must be documented in the case file.

The case manager shall visit with an individual in his/her place of residence every six months and review and update the assessment and the individual's care plan as necessary.

A comprehensive assessment must be completed initially and annually thereafter for the individual or if there has been a significant change in personal care needs. The comprehensive assessment must include information on the individual's physical health, cognitive and emotional functioning, ability to perform activities of daily living or instrumental activities of daily living, informal supports, need for 24 hour supervision, social participation, physical environment, financial resources, and any other pertinent information about the individual or his/her environment.

After completing the comprehensive assessment, the case manager and individual work together to develop a plan for the individual's care based on the individual's needs, situations, and problems identified in the assessment. The individual and case manager work together to develop a comprehensive plan of care that is recorded in the individual's case file, authorized on the Authorization to Provide Personal Care Services SFN 663, and summarized on the Personal Care Services Plan SFN 662. The plan must include:

1. All problems identified, including those that will not be addressed through the provision of personal care services.

2. Desired outcome(s) for each problem must be documented in the comprehensive assessment for which units of personal care services have been authorized.

3. The type(s) of help needed to achieve each desired outcome.

4. Services and providers that can supply the need for help.

5. Provider(s) the individual selects.

6. The amount of personal care service to be provided and the specific time-period.

7. Documentation of the medical necessity to monitor vital signs and identify who is to be notified of an individual's vital signs readings.

The case manager shall identify personal care service providers available to provide the service required by the individual and provide the following information to the individual:

1. Name, address and telephone number of available personal care service providers.

2. Identify whether a provider is an agency or individual QSP or a basic care assistance provider.

3. Any limitations applicable to the available providers.

4. If applicable, any global or individual specific endorsements for specialized cares that available providers are qualified to perform.

The individual must select the personal care service provider(s) they want to deliver the service to meet their care needs. The case manager must then complete an Authorization to Provide Personal Care Services, SFN 663, for each provider selected and finalize the Personal Care Services Plan, SFN 662.

The case manager must monitor and document that the individual is receiving the personal care services authorized on SFN 663. The case manager must review the quality and quantity of services provided. A reassessment of the individual's needs and care plan must be completed at a minimum of six-month intervals.

The case manager is responsible for following Department established protocols when abuse, neglect or exploitation of an individual is suspected.

Standards for Targeted Case Management (TCM) for persons in need of Long term Care.

- The service shall be performed by a social worker or agency who employs individuals licensed to practice social work in North Dakota and who has met all the requirements to be enrolled as either an Individual or Agency Qualified Service Provider (QSP) or an Indian Tribe/Indian Tribal Organization who has met State Plan requirements and requirements to be enrolled as a QSP or Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professional (QMRP) or has one year experience as a DDPM with the Department.

The following enrolled provider types are eligible to receive payment for TCM:

- Case Managers employed by a County Social Service Agency who have sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Developmental Disabilities Program Manager (DDPM) who is a Qualified Mental Retardation Professional (QMRP) or has one year experience as a DDPM with the Department.

- An Individual Case Manager or Agency Case Manager that has sufficient knowledge and experience relating to the availability of alternative long term care services for elderly and disabled individuals.

- Indian Tribe or Indian Tribal Organization who has met the provider qualifications outlined in the North Dakota State Plan Amendment

The following enrolled provider types are eligible to receive payment for TCM and Authorize MSP-PC Service:

- Case Managers employed by a County Social Service Agency (also eligible to approve services under SPED and EXSPED See Chapter 525-05-25).

- Developmental Disabilities Program Managers (DDPM)

    - If the client is a recipient of services funded by the SPED, Expanded SPED Programs, or MSP-PC the one case file will contain documentation of eligibility for TCM as well as for the service(s)

The following enrolled provider types are eligible to receive payment for single event TCM:

- County HCBS Case Managers, DDPMs, enrolled Individual or Agency Case Managers and enrolled Indian Tribe or Indian Tribal Organizations.

    - If the client requests a contact more than once every six months the Case Manager needs to obtain prior approval from a HCBS Program Administrator.

    - Indian Tribe or Indian Tribal Organizations are limited to providing TCM Services to enrolled tribal members.

<u>Targeted Case Management (TCM)</u>

The individual receiving TCM will meet the following criteria:

1. Medicaid recipient.

2. Not a recipient of HCBS (1915c Waiver) services.

3. Not currently be covered under any other case management/targeted case management system or payment does not duplicate payments made under other program's authorities for the same purpose

4. Lives in the community and desires to remain there; or be ready for discharge from a hospital within 7 days; or resides in a basic care facility; or reside in a nursing facility if it is anticipated that a discharge to alternative care is within six months.

5. Case management services provided to individuals in Medical institutions transitioning to a community setting. Services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between the ages of 22-64 who are served in Institutions for Mental Disease or inmates of public institutions.

6. Has "long-term care need." Document the required "long-term care need" on the Application for Services, SFN 1047. The applicant or legal representative must provide a describable need that would delay or prevent institutionalization.

7. The applicant or referred individual must agree to a home visit and provide information in order for the process to be completed.

Activities of Targeted Case Management

1-Assessment/Reassessment

2-Care Plan Development

3-Referral and Related Activities

4-Monitoring and Follow-up Activities

- The focus or purpose of TCM is to identify what the person needs to remain in their home or community and be linked to those services and programs.

- An assessment must be completed and a Care Plan developed. The client's case file must contain documentation of eligibility for TCM. The HCBS Comprehensive Assessment must be entered into the SAMS Web Based System or the THERAP System/MSP-PC Functional Assessment.

- Targeted case management is considered a "medical need" and thus included as a health care cost. Use of Medicaid funding for targeted case management may result in the recipient paying for/toward the cost of their case management. The client must be informed of that fact by noting Case Management Service and cost on the Individual

Care Plan. Clients must also check and sign acknowledgment that if they are on Medicaid they may have a recipient liability. Payments from the Medicaid Program made on behalf of recipients 55 years or older are subject to estate recovery including for Targeted Case Management.

- The case record must include a HCBS Comprehensive Assessment and narrative which includes:
    - Name of the individual,
    - Dates of case management service,
    - Name of the case management provider/staff.
    - Nature, content , units of case management service received, and whether goals specified in the plan are achieved
    - Whether the individual has declined services in the care plan
    - Coordination with other case managers,
    - TimeLine of obtaining services,
    - Timeline for reevaluation of the plan

Limits:

Case management does not include direct delivery of services such as counseling, companionships, provision of medical care or service, transportation, escort, personal care, homemaker services, meal preparation, shopping or assisting with completion of applications and forms (this is not an all-inclusive list).

Case file documentation must be maintained:

1. In a secure setting
2. On each individual in separate case files

If case management is not provided under any waivered service, Targeted Case Management must be identified on the Personal Care Services Plan, SFN 662.

An individual must be given a "Your Rights and Responsibilities" brochure, DN 46 (available through Office Services), and verification of receipt of the brochure must be noted on SFN 1047, Application for Services, or in the documentation of the assessment.

Payment for Services 535-05-40

Payment for personal care services may not be made unless the client has been determined eligible to receive Medicaid benefits.

A personal care service provider enrolled as a qualified service provider shall be paid based on 15 minute increments using a provider specific 15 minute unit rate, which may not exceed the maximum 15 minute unit rate established by the department.

A personal care service provider enrolled as a qualified service provider, who resides with an individual eligible to receive personal care services, may elect to be paid a daily rate for each day personal care services are provided for at least 15 minutes. The daily rate may not exceed the maximum per day rate established by the department and may be paid to no more than one QSP.

A personal care service provider enrolled as a basic care assistance provider shall be paid a daily rate if personal care services are needed and provided every day. The daily rate is an average per day rate that is provider specific and may not exceed the maximum per day rate established by the department. The daily rate is applicable to all eligible individuals needing and receiving daily personal care services from the basic care assistance provider and does not vary based on the amount of services provided daily. If personal care services are provided intermittently to an individual, the basic care assistance provider shall be paid based on the maximum agency 15 minute unit rate for the services provided to that individual.

Case management activities must be documented in the case file before payment for case management can be requested. The authorizing agent may be paid for targeted case management (TCM) for a Medicaid eligible individual in need of long term care services only if the individual is not receiving case management under any HCBS waiver or other targeted case management provisions. No claim may be made for TCM when a change in funding source for case management occurs or if an individual is not eligible for Medicaid. When accessing Targeted Case Management payment, documentation must support that the individual is at risk of requiring long-term care services this can be narrated on the SFN 1047, Application for Services.